FILE COPY

LAW OFFICES
MICHAEL B. GANSON CO., L.P.A.
36 EAST SEVENTH STREET, SUITE 1540
CINCINNATI, OHIO 45202-4463
TELEPHONE 513-721-2220
FAX 513-721-5109
E-MAIL Gansonlawoffice@aol.com

MICHAEL B. GANSON*
KENNETH HEUCK, JR.
OF COUNSEL
*ALSO ADMITTED IN FLORIDA

FINNEYTOWN OFFICE
8464 WINTON RD.
CINCINNATI, OHIO 45231

MONTGOMERY OFFICE
10495 MONTGOMERY RD.
CINCINNATI, OHIO 45242

November 12, 2003

Jamie M. Ramsey, Esq.
Keating, Muething & Klekamp, PLL
One E. Fourth Street, Suite 1400
Cincinnati, OH 45202

Re: Melton, et al., vs.
Board of County Commissioners of Hamilton County, Ohio, et al.
U.S. District Court Southern District of Ohio, Western Division
Case No: C-1-01-528
Our File No: G-249-00

Dear Mr. Ramsey:

Enclosed are the HIPPA forms we recently received from Ms. Brenda Martin as you requested in connection with the above-referenced matter. We have requested Ms. Martin to forward the original forms to us at her earliest opportunity. We will forward them to you upon receipt. I am still waiting and pressing my clients for the additional information and documentation and will forward it immediately upon receipt as well.

If you have any questions, please contact me. I trust this missive shall satisfy you so a motion to compel need not be filed. Please contact us if otherwise.

Very truly yours,

Michael B. Ganson

MBG/mcp
Enclosures
D:\MELVA\249-00\CounselRamsey 11-12-03.wpd

EXHIBIT
F

LAW OFFICES
MICHAEL B. GANSON CO., L.P.A.
36 EAST SEVENTH STREET, SUITE 1540
CINCINNATI, OHIO 45202-4463
TELEPHONE 513-721-2220
FAX 513-721-5109
E-MAIL Gansonlawoffice@aol.com

MICHAEL B. GANSON*
KENNETH HEUCK, JR.
OF COUNSEL
*ALSO ADMITTED IN FLORIDA

FINNEYTOWN OFFICE
8464 WINTON RD.
CINCINNATI, OHIO 45231

MONTGOMERY OFFICE
10495 MONTGOMERY RD.
CINCINNATI, OHIO 45242

October 7, 2003

Ms. Brenda Martin
303 Emming Street, #2
Cincinnati, OH 45219

Re: Melton, et al., vs.
Board of County Commissioners of Hamilton County, Ohio, et al.
U.S. District Court Southern District of Ohio Western Division
Case No: C-1-01-528
Our File No: G-249-00

Dear Brenda:

As discussed, enclosed are the HIPAA Authorization Forms you requested to be sent to you again. Please sign, date, and return the enclosed forms to us for handling. Please make any corrections you deem necessary directly on the form.

If you have any questions, please contact us. We look forward to hearing from you. We will continue to keep you fully informed as developments occur. Please do likewise. Thank you for allowing us to be of service to you in this as well as the other matters I am handling on your behalf.

Very truly yours,

Melva

Melva C. Pechiney, Legal Assistant to
Michael B. Ganson

MCP/bmp
Enclosures
D:\MELVA\249-00\MeltonFam-MartinBrenda 10-7-03.wpd

HIPAA AUTHORIZATION FORM

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. seq., and regulations promulgated thereunder, as amended from time to time (collectively referred to as "HIPAA").

I authorize: Core Behavior ("Covered Entity")
~~Stephanie Armstrong~~ Bill Devore
Brenda Martin

to disclose a copy of the specific health and medical information identified below for:

Brenda Martin (Name/Address of Patient)
303 Emming Street 2 49
Cinti, OH 19

to: Jamie Ramsey
Keating, Muething & Klekamp, P.L.L.
1400 Provident Tower
One East Fourth Street
Cincinnati, OH 45202

for the following purposes: ______________________________

By initialing the spaces below, I specifically authorize the use and disclosure of the following health information and medical records, if such information and record exists:

BM **Please Send the Entire Medical Record (All Information) to the Above Named Recipient.**

BM All Hospital Records (Including Nursing Records And Progress Notes)

BM Transcribed Hospital Reports

BM Dental Records

BM Transcribed Hospital Reports

BM Laboratory Reports

BM Most Recent Five Year History

BM Pathology Reports

BM Emergency And Urgent Care Records

BM Diagnostic Imaging Reports

BM Billing Statements

_____ Other: ____

____

I understand that this authorization includes but is not limited to: (1) HIV/AIDS related information and records; (2) mental health information and records; (3)genetic testing information and records; and (4) drug or alcoholism related diagnosis, treatment or referral information.

You have the right to revoke this authorization, in writing, at any time, except to the extent that Covered Entity has taken action in reliance on it. A revocation is effective upon receipt by Covered Entity of a written request to revoke and a copy of the executed authorization form to be revoked at the address listed above.

This authorization shall expire upon the earlier occurrence of: (1) revocation of the authorization; (2) complete satisfaction of the purposes for which this authorization was originally obtained, or (3) ten years from the date this authorization was executed.

HIPAA AUTHORIZATION FORM

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. seq., and regulations promulgated thereunder, as amended from time to time (collectively referred to as "HIPAA").

I authorize: Central Clinic ("Covered Entity")
~~Bill Devore~~ Stephanie Armstrong
Brenda Martin

to disclose a copy of the specific health and medical information identified below for:

Brenda Martin (Name/Address of Patient)
303 Emming Street 2nd
Cinti, OH 19

to: Jamie Ramsey
Keating, Muething & Klekamp, P.L.L.
1400 Provident Tower
One East Fourth Street
Cincinnati, OH 45202

for the following purposes: ______________________________

____

______________________________.

By signing this authorization you acknowledge and agree that any information used or disclosed pursuant to this authorization could be at risk for redisclosure by the recipient and no longer protected under HIPAA.

Acknowledged and agreed to by:

PATIENT:

By Brenda Martin   10/22/03
Print Name Brenda Martin   Date
Address: 303 Emming Street 2nd
Cincinnati
OH 45219

or, ON BEHALF OF PATIENT

By__________ __________
Print Name__________ Date
As__________

Address:__________

By initialing the spaces below, I specifically authorize the use and disclosure of the following health information and medical records, if such information and record exists:

BM **Please Send the Entire Medical Record (All Information) to the Above Named Recipient.**

BM All Hospital Records (Including Nursing Records And Progress Notes)

BM Transcribed Hospital Reports

BM Most Recent Five Year History

BM Emergency And Urgent Care Records

BM Billing Statements

BM Transcribed Hospital Reports

BM Dental Records

BM Laboratory Reports

BM Pathology Reports

BM Diagnostic Imaging Reports

_____ Other: ____

____

I understand that this authorization includes but is not limited to: (1) HIV/AIDS related information and records; (2) mental health information and records; (3)genetic testing information and records; and (4) drug or alcoholism related diagnosis, treatment or referral information.

You have the right to revoke this authorization, in writing, at any time, except to the extent that Covered Entity has taken action in reliance on it. A revocation is effective upon receipt by Covered Entity of a written request to revoke and a copy of the executed authorization form to be revoked at the address listed above.

This authorization shall expire upon the earlier occurrence of: (1) revocation of the authorization; (2) complete satisfaction of the purposes for which this authorization was originally obtained, or (3) ten years from the date this authorization was executed.

By initialing the spaces below, I specifically authorize the use and disclosure of the following health information and medical records, if such information and record exists:

BM **Please Send the Entire Medical Record (All Information) to the Above Named Recipient.**

BM All Hospital Records (Including Nursing Records And Progress Notes)

BM Transcribed Hospital Reports

BM Most Recent Five Year History

BM Emergency And Urgent Care Records

BM Billing Statements

BM Transcribed Hospital Reports

BM Dental Records

BM Laboratory Reports

BM Pathology Reports

BM Diagnostic Imaging Reports

_____ Other: ____

____

I understand that this authorization includes but is not limited to: (1) HIV/AIDS related information and records; (2) mental health information and records; (3)genetic testing information and records; and (4) drug or alcoholism related diagnosis, treatment or referral information.

You have the right to revoke this authorization, in writing, at any time, except to the extent that Covered Entity has taken action in reliance on it. A revocation is effective upon receipt by Covered Entity of a written request to revoke and a copy of the executed authorization form to be revoked at the address listed above.

This authorization shall expire upon the earlier occurrence of: (1) revocation of the authorization; (2) complete satisfaction of the purposes for which this authorization was originally obtained, or (3) ten years from the date this authorization was executed.